



Prior Authorization Request Form – HMG-CoA Reductase Inhibitors

Instructions:

This form is to be used by participating providers to request coverage for HMG-CoA Reductase Inhibitor drugs requiring prior authorization. Please fill out this form COMPLETELY, including signature, and fax to MedMetrics Health Partners at 1-800-918-7542. Allow 24 hours to process request. Please call MedMetrics PA Line (available 24 hours a day) at 1-800-918-7550 for more urgent requests.

MedMetrics Health Partners – Prior Authorization Services
 P. O. Box 2586, Worcester, MA 01606

Phone: 1-800-918-7550
 Fax: 1-800-918-7542

A HMG-CoA reductase inhibitors step therapy program has been developed to encourage the use of first-line therapies before second or third-line therapies are used for the same indication. If approved, quantity limits apply.		
<u>First-line therapies:</u>	<u>Second-line therapies:</u>	<u>Third-line therapies:</u>
lovastatin	Atoprev (lovastatin extended-release)	Lipitor (atorvastatin)
pravastatin	Crestor (rosuvastatin)	Vytorin (ezetimibe/simvastatin)
simvastatin	Lescol/XL (fluvastatin)	

Please PRINT and complete ALL of the following boxes:

1. Member's FULL Name:	2. Member's NHP ID Number:	3. Member's DOB: (mm/dd/yy)
4. Prescriber's FULL Name & Specialty: Mailing Address:		5. Contact Person at Office:
6. Prescriber's FAX & Telephone Number: Fax: () Tel: ()	7. Primary Diagnosis/Indication:	
8. Requested Drug:	9. Dose, Frequency and Duration of Requested Drug:	
10. Please list other medications the member is currently taking:		
11. Does the member have a history of Acute Coronary Syndrome (i.e., STEMI, NSTEMI, Unstable Angina): <input type="checkbox"/> Yes (please specify): _____ <input type="checkbox"/> No		
12. Is the member currently taking warfarin (Coumadin)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
13. Is the member currently taking a protease inhibitor or a protease inhibitor-containing regimen? <input type="checkbox"/> Yes (please specify): _____ <input type="checkbox"/> No		
14. Has the member previously tried the following?		
Drug Name (please check all that apply)	Response (please check all that apply)	
<input type="checkbox"/> simvastatin	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy	
15. Has the member previously tried the following? (Please complete if requesting a third-line therapy.)		
Drug Name (please check all that apply)	Response (please check all that apply)	
<input type="checkbox"/> Atoprev (lovastatin extended-release)	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy	
<input type="checkbox"/> Crestor (rosuvastatin)	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy	
<input type="checkbox"/> Lescol/XL (fluvastatin)	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy	
<input type="checkbox"/> Other (please specify): _____	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy	
16. Prescriber comments:		

Signature:

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

 Prescriber's signature

 Date